

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016327
STATE FILE NUMBERDO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 60

FILED MAY 3 1962

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana</u>		c. CITY OR TOWN <u>Louisiana</u>	
Length of stay in 1b <u>10 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>710 N. Eighth St.</u>		d. STREET ADDRESS (If outside, give location) <u>710 N. Eighth St.</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Ira</u> Last <u>McDaniel</u>			4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/1897</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Pacific, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Alfred McDaniel</u>		13b. MOTHER'S MAIDEN NAME <u>Lizzie Shultz</u>	
14. NAME OF HUSBAND OR WIFE <u>Rosetta McDaniel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Rosetta McDaniel, Louisiana, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Coronary Thrombosis & myocardial infarction</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>Unknown</u>	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u>9:10</u> a.m. Month, Day, Year <u>4-24-62</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>4-24-62</u> to <u>4-24-62</u> and last saw him alive on <u>4-24-62</u>
21. I attended the deceased from <u>9:10 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Per Y. Brotnson MD.</u>	22b. ADDRESS <u>218 N 5th St Louisiana Mo</u>	22c. DATE SIGNED <u>4-25-62</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>APRIL 27, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETHANY CEMETERY</u>	23d. LOCATION (City, town, or county) <u>LINCOLN Co., Mo</u>
24. FUNERAL DIRECTOR <u>Collier Funeral Service,</u>	25. DATE RECD. BY LOCAL REG. <u>April-25/1962</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

Collier Funeral Service,
Louisiana, Missouri

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59108222082234 65 167 08 094201101112 90-213 2-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Geo. M. Collier

Licensed Embalmer No.

3829

P. O. Address

Rocky Mountain, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.